



# NM Breast and Cervical Cancer Early Detection (BCC) Program Clinic-Based Patient Navigation (PN) Form

FY25: July 2024 – June 2025

CLINIC AND LOCATION/CITY:

BCC ENROLEE NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE NUMBER(S): \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_ ID#: \_\_\_\_\_

Navigated by (list all): \_\_\_\_\_

Patient Navigation Initiation Date: \_\_\_\_\_  Check box if form is an UPDATE to a previously submitted PN form.

Reason for Initiating Navigation: reimbursement for BCC enrolled people only

- BREAST:  Screening  Follow-up of Abnormal Results  Treatment Initiation  
 CERVICAL:  Screening  Follow-up of Abnormal Results  Treatment Initiation

**CDC/NBCCEDP Timeliness Guidelines:**

- 60-days from abnormal breast/cervical screening to diagnosis
- 60-days from breast/cervical cancer diagnosis to treatment

Date of Abnormal Screening Result: \_\_\_\_\_ Date of Final Diagnosis: \_\_\_\_\_ Date Treatment Started: \_\_\_\_\_

<b>BARRIER</b> MARK ALL THAT APPLY	For each <u>actual</u> contact, MUST record: date of contact, how contacted, and a short description of the conversation between client and navigator including all barriers identified and the plan for resolution. Actual contact means the client and navigator spoke. <b>At least 3 actual contacts are recommended; must be no fewer than 2 for reimbursement.</b>
<input type="checkbox"/> Language or Cultural Concerns	Actual Contact #1 - Date: _____ How Spoke with Client: <input type="checkbox"/> In-Person <input type="checkbox"/> Phone <input type="checkbox"/> Other (e.g., Telehealth Visit)
<input type="checkbox"/> Cost, Financial, or Insurance Coverage	
<input type="checkbox"/> Transportation Issues	
<input type="checkbox"/> Child or Elder Care, or Other Family Obligations	Actual Contact #2 - Date: _____ How Spoke with Client: <input type="checkbox"/> In-Person <input type="checkbox"/> Phone <input type="checkbox"/> Other (e.g., Telehealth Visit)
<input type="checkbox"/> Fear of Medical Test(s) or Cancer	
<input type="checkbox"/> School, Work Schedule or Employment	
<input type="checkbox"/> Understanding Medical Needs	Actual Contact #3 - Date: _____ How Spoke with Client: <input type="checkbox"/> In-Person <input type="checkbox"/> Phone <input type="checkbox"/> Other (e.g., Telehealth Visit)
<input type="checkbox"/> Discomfort, Pain, Disabilities, or Other Health Issues	
<input type="checkbox"/> OTHER: _____	

**Outcome of Patient Navigation:** Mark box and add notes if needed.

Complete			
Incomplete			
In Process			

**Total Actual Contacts:** \_\_\_\_\_  
(3 OR MORE ACTUAL CONTACTS RECOMMENDED BUT MUST HAVE AT LEAST 2)

**CLOSEOUT DATE:** \_\_\_\_\_

**CLIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Actual Contact #4 - Date: \_\_\_\_\_ How Spoke with Client:  In-Person  Phone  Other (e.g., Telehealth Visit)

Actual Contact #5- Date: \_\_\_\_\_ How Spoke with Client:  In-Person  Phone  Other (e.g., Telehealth Visit)

Actual Contact #6 - Date: \_\_\_\_\_ How Spoke with Client:  In-Person  Phone  Other (e.g., Telehealth Visit)

Actual Contact #7 - Date: \_\_\_\_\_ How Spoke with Client:  In-Person  Phone  Other (e.g., Telehealth Visit)

Actual Contact #8 - Date: \_\_\_\_\_ How Spoke with Client:  In-Person  Phone  Other (e.g., Telehealth Visit)